# OUT-PATIENT CLAIM FORM

Practitioners Name Dr. FirstName1 SecondName1

**Practitioner's Official Stamp**

Postal Address Kanpala, Uganda

Tel No. 256731253678 Mobile 256735234987

Email ugandatestuser434@test.dev

## PATIENT'S PARTICULARS

Full Name of Patient PFirstName PSecondName Date of Birth 01/11/1920

Full Name of Member (if patient is a dependant) Specimen1 Sample1

Member's Tel No. 0720000001 Member No. 100001

Member's Employer Name Sample1 Company (K) Ltd Dept. /Branch Department1 Sample1

Have you suffered from this sickness in the past? YES NO

If YES, when did it start and how frequent is it? N/A

## CONSULTATION/REFERRALS DIAGNOSIS:

**TREATMENT PRESCRIBED**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **MEDICINES:** | Prescription | | Injection given | | Dispensed | | None | |
| **RADIOLOGY:** | X-Ray | | MRI/Cat Scan | | Other | | Other | |
| **PATHOLOGY:** | Haematology | | Microbiology | | Biochemistry | | Histology | |

Hospital Name: Consultant Referred To: Specialty:

**MEDICATION PRESCRIBED:**

Sample 1, Sample 11

**Dr's Signature** TTTTT **Date** 02/10/2023

**DECLARATION**

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

**Member's Signature** YYYYYY **Date** 01/01/2023

**UAP Insurance Company Limited**
UAP Old Mutual Tower, Upperhill Road. P.O Box 43013-00100 Nairobi, Tel: +254 711 065 100 / +254 20 285 0000
Email: uapoutpatient@uapoldmutual.com Website: www.uapoldmutual.com